Kentucky Board of Social Work
COMMONWEALTH OF KENTUCKY
PO BOX 1360
FRANKFORT, KY 40602
http://www.state.ky.us/agencies/finance/occupations/socialwork/index.htm

BOARD USE ONLY

Approval Date: _____

Ending Date: _____

SUPERVISION CONTRACT FOR CLINICAL SOCIAL WORK PRACTICE

Instructions:

1. Read the application and instructions carefully before filling out application. Answer all questions. If the answer is 'no' or 'none', please indicate. If non-applicable, indicate N/A. If additional space is needed, attach separate sheets.
2. Please type or print legibly.
3. If experience is from multiple work settings or supervision from more than one supervisor is planned, complete the following information for each.
4. ***YOU MUST INCLUDE A CURRENT OFFICIAL AGENCY JOB DESCRIPTION SIGNED BY THE EXECUTIVE DIRECTOR, HUMAN RESOURCES DIRECTOR, OR AGENCY SUPERVISOR.***

APPLICANT'S NAME: _____ CSW LICENSE #. _____ ISSUE DATE: _____

APPLICANT'S ADDRESS: _____
Street City State Zip

PLEASE SELECT THE CATEGORY OF APPROVAL WHICH YOU ARE SEEKING:

____ **Clinical practice contract** - a CSW who desires to practice clinical social work which does not qualify as supervised experience shall submit a supervision contract pursuant to KRS 335.080(3) and 201 KAR 23:070 Section 8(c)(2).

____ **Pre-approved evaluation** – candidates not otherwise exempted under KRS 335.101(3), (4), or (5) shall submit a contract for the experience which will be taking place over the required time period and have the contract approved by the board **prior to beginning supervision.** This contract shall be evaluated by the board and shall be approved or disapproved within ninety (90) days of its submission. Any job changes or supervisory changes must be reported to the Board.

____ If you have previous supervision hours you wish to submit *(from an agency exempt from Kentucky law or from employment held out of state)* please check and submit the **"Supervised Experience Documentation Form for Licensed Clinical Social Worker" (Part I, II, III)** along with this completed supervision contract form.

CURRENT CLINICAL SOCIAL WORK SETTING

FACILITY NAME: _____ Phone: ( ) _____

FACILITY OWNER: _____

Does the agency subcontract the mental health component? ____ yes ____ no If yes, to what entity?

_____

Facility Address: _____
Street, P. O. Box #, etc. City State Zip Code

SUPERVISOR OF RECORD

A. Name: _____ Kentucky LCSW license # _____ Issue Date: _____

B. Address: _____
Street City State Zip Code

C. Telephone: Home: ( ) _____ Office: ( ) _____

D. Date of Supervisory Training **(attach copy of certificate)**: _____

ADDITIONAL SUPERVISOR/S (If you will be receiving supervision from any other supervisor, please list each one)

1A. Name: _____ Kentucky LCSW license # _____ Issue Date: _____

1B. Address: _____
Street City State Zip Code

1C. Telephone: Home: ( ) _____ Office: ( ) _____

1D. Date of Supervision Training **(attach copy of certificate)**: _____

2A. Name: _____ Kentucky LCSW license # _____ Issue Date: _____

2B. Address: _____
Street City State Zip Code

2C. Telephone: Home: ( ) _____ Office: ( ) _____

2D. Date of Supervision Training **(please attach certificate)**: _____

SHARED RESPONSIBILITY FOR SUPERVISION RECEIVED OUTSIDE OF EMPLOYMENT SETTING

If the supervision for the activities listed in this application is to be received outside the applicant's place of employment, the section below must be completed and signed by the supervisor of record, the applicant, and an authorized person representing the agency.

We the undersigned, do hereby acknowledge the sharing of professional responsibility between _____
(Name of Agency)

and _____ for the clinical social work service provided to clients of the above named
Supervisor of record

agency by _____ and are jointly to be held accountable for the quality of the service
Applicant

provided. We further acknowledge that since the supervision outlined previously will take place outside the agency of employment and that agency cases will be used in this supervisory relationship, complete and total confidentiality of patient records will be maintained by all parties throughout the period.

_____

_____

Signature of Supervisor of Record Certificate No. Date

Signature of Additional Supervisor (if applicable) Certificate No. Date

Signature of Applicant Certificate No. Date

Signature of Agency Representative Date

PLAN OF CLINICAL SOCIAL WORK ACTIVITIES

A. A detailed description of the nature of this practice is: (i.e., what types of activities, therapies, counseling, etc.; will they be individuals, couples, groups, etc.; length and duration of therapy)

B. A detailed description of the nature, duration, and frequency of the supervision in this practice is: (i.e. how often and how long are supervisory sessions; what will be done in supervisory sessions; how will they be conducted)

C. A detailed description of the conditions or procedures for termination of this relationship is:

_____

_____

_____

_____

_____

_____

_____

D. Hours per week spent in direct client-professional relationship. _____ (include clinical diagnosis and treatment only)
This requires eighteen (18) hours for full-time and twelve (12) hours for part-time.

AFFIDAVIT

I, the supervisor of record for the above named candidate for licensure as a licensed clinical social worker, have devised and discussed this plan with said applicant and accept responsibility for its implementation. Further, I understand that upon completion of the plan of supervised activities for clinical social work experience and application for examination, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changed, I will immediately notify the board. Further, I do hereby certify that my Kentucky license is current, and will be maintained throughout this period.

Signature of Clinical Supervisor _____ **Date** _____

I, the applicant in the above plan, understand that I will be expected to comply with the provisions of this plan in its entirety and must notify the Board of any modifications of this plan once it has been approved by them. Failure to do so may result in voiding of the approval given by the Board and loss of supervision hours gained.

Signature of Applicant _____ **Date** _____

AGENCY SUPERVISOR

If the supervision listed in the Plan of Clinical Social Work Activities in this application is provided by someone other than the applicant's agency supervisor, the agency supervisor must review the proposed plan and sign the statement below:

As agency supervisor of the above named candidate, I affirm the agency will support the proposed practice experience as described in A of this page.

Signature of Agency Supervisor _____ **Date** _____

NOTE: KRS 335.080 states "no certified social worker shall enter into a practice of clinical social work until this contract has been approved by the Board".